At 20 November 1971

Antibiotic Sensitivity Testing

SIR,—Editorial comment (22 May, p. 416) highlighted once again the need for a technique of antibiotic sensitivity testing which will allow meaningful comparisons to be made between different countries, and the desirability of a statement of policy in the United Kingdom on the method to be used.

The work of H. M. Ericsson, presented at St. Thomas's Medical School in 1966, persuaded me to study this type of method. Using commercially available materials (Oxoid Ltd., London) thirteen antimicrobial agents were studied, regression curves calculated, and reported in 1969. Controversy on interpretation of such methods still continues—six years later.

While adoption of the Bauer-Kirby method proceeds in some areas, others adopt that of Ericsson. Automated zone analysers are now commercially available and will reduce the laboratory problems to some extent. If some standardization of method is to be adopted before international differences become too entrenched some policy should be made and be seen to be adopted in the United Kingdom. Many overseas workers observe and are influenced by the opinions expressed and actions of those in Great Britain.—I am, etc.,

JOHN NEAL
Department of Medical Technology,
Western Australian Institute of Technology,
Australia.


Digoxin and A-V Block

SIR.—We should like to take exception to the conclusions drawn regarding the effect of digoxin on A-V conduction in the article by Dr. R. A. J. Spurrell, Dr. A. M. Harris, and Mr. M. R. Howard (4 September, p. 563) and offer the following comments:

(1) Terminology.—The criteria for the diagnosis of “complete heart block” are not stated. If these were the criteria of “complete A-V dissociation” a serious and notorious error may have occurred, since A-V dissociation in acute inferior wall infarction is frequently caused by an accelerated junctional pacemaker in the absence of any A-V block or in the presence of only lesser degrees of A-V block. Neither atrial nor ventricular rates during “complete” A-V block are listed, nor is the sub-sidiary pacemaker mentioned.

(2) Type of block (site of lesion) and digitalis effect.—No distinction is made between second degree A-V block of type I (Wenckebach) and type II (Mobitz). Since digitalis depresses mainly A-V nodal transmission it has little or no effect on supraventricular conduction, and the type of second degree block should be indicated in an evaluation of digitalis effect on A-V conduction.—We are, etc.,

RICHARD LANGENDORFF
ALFRED PICK
Cardiovascular Institute,
Michael Reese Hospital and Medical Center,
Chicago, Ill., U.S.A.

5 Sutton, R. J., and Davies, M., Circulation, 1968, 38, 987.

Epidemic Keratoconjunctivitis

SIR,—We wish to support the timely warning given by Mr. J. D. C. Hart and his colleagues (23 October, p. 229) that outbreaks of epidemic keratoconjunctivitis are occurring in the United Kingdom at present. Since